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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Leza Wainwright

SUBJECT: Implementation Update #76
Reporting Provider Fraud and Abuse
Changes to Administrative Requirements
CAP-MR/DD Clinical Policy/Manuals & Technical Amendment Number One
Direct Billing for I/DD TCM Providers
Update on New PA Guidelines for Outpatient
CABHA Transition Updates
CABHA Review Process
Medicaid Enrollment for CABHA Applicants
Incident Response and Improvement System
Community Support Team Providers

Reporting Provider Fraud and Abuse

The N.C. Department of Health and Human Services (DHHS) has created a poster asking citizens to report Medicaid fraud and abuse. In a memo dated June 4, 2010, DHHS Secretary Lanier Cansler asked all health care agencies and private health care providers to print and prominently display the poster in their offices (see attached documents). We appreciate your participation in this important effort. For more information, please refer to the Division of Medical Assistance (DMA) website at http://www.ncdhhs.gov/dma/provider/fraud.htm.

Changes to Administrative Requirements for Providers and LMEs

In response to 2009 legislation (SL 2009-451 Section 10.18b), the DHHS has worked with representatives from provider agencies and local management entities (LME) over the past fiscal year to find ways to make paperwork requirements and processes more efficient. As a result, DHHS has implemented the following changes, which have been reported in previous Implementation Updates:

- Revision of the Person Centered Plan (PCP) form and requirements

- Revision of the authorization requirements and payment structure for targeted case management
- Simplification of the documentation requirements for psychosocial rehabilitation services
- Greater weight for providers' accreditation status in LME monitoring decisions
- Implementation of a web-based Incident Response Improvement System (in process)
- Addition of management tools and report extraction capacity in NC-Treatment Outcomes and Program Performance System (NC-TOPPS) (in process)

The provider and LME workgroups also identified additional areas to be streamlined in the coming year. These include:

- Creating greater consistency in the screening, triage and referral process and data submitted to LMEs
- Making additional revisions to the PCP form
- Creating greater consistency in the data elements and submission timeframes for information that providers send to LMEs
- Improving the sharing of consumer information between LMEs and providers who serve them
- Improving consistency in trainings through web-based training methods
- Sharing resources and tips on how to provide quality services
- Improving inter-rater reliability among monitoring staff

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) will work with the NC Council of Community Programs and providers in SFY 2010-11 to determine the best methods for addressing these additional areas for improvement. Questions and suggestions may be submitted to ContactDMHQuality@dhhs.nc.gov.

Implementation of the CAP-MR/DD Clinical Policy/Manuals and Technical Amendment Number One

The DMH/DD/SAS in partnership with DMA have completed the process for the development of the CAP-MR/DD Clinical Policy. This process includes: securing approval from the Physician's Advisory Group (PAG), posting for public comment, processing feedback received from public comments and making final revisions to the policy. This serves as formal notice of the release and implementation of the CAP-MR/DD Clinical Policy in conjunction with the manuals for the CAP-MR/DD Supports Waiver and the Comprehensive Waiver. Also included are the changes and implementation plan and schedule to phase in the changes contained in the CAP-MR/DD Clinical Policy, Supports Waiver and Comprehensive Waiver Manuals and Technical Amendment Number One.

The CAP-MR/DD Clinical Policy contains the service definitions, the utilization review guidelines and other clinical elements of the CAP MR/DD Comprehensive Waiver and Supports Waiver. The CAP MR/DD Comprehensive Waiver and Supports Waiver Manuals contain all the operational details and expectations related to the waivers, in addition to the information contained in the Clinical Policy.

Technical Amendment Number One provides the following changes/clarifications to both the Comprehensive Waiver and the Supports Waiver:

1. Revision to the **Behavioral Consultant** service definition in response to public comment. Removed Level I of the service. **Behavioral Consultant now has Level II and Level III.** These levels are intended to provide an increasing level of support based on the intensity of need of the participant. The required staff qualifications were modified to be consistent with the intensity of the service and the participant's needs.

   Behavioral Consultant II
   Behavioral Consultant II is intended for individuals whose intensity of need is greater than what can be accommodated by other available waiver (Specialized Consultative Services) and Medicaid community services.

   Modified Required Staff Qualifications
   Individuals providing **Behavioral Consultant II shall meet all of the following staffing requirements**

- *Licensed* psychologist, *licensed* psychological associate, or *licensed* social worker in the state of North Carolina; and
- Board certified Behavior Analysis or two years supervised experience with intellectual and developmental disabilities (I/DD) and extreme challenging behaviors (functional behavioral assessments, development and monitoring behavior plans)

Behavioral Consultant III
Behavioral Consultant III is intended for individuals who exhibit severe aggression, self-injury, and other dangerous behaviors. Level III requires staff with a higher level of experience working with individuals with these extreme behavioral challenges.

Modified Required Staff Qualifications
Individuals providing **Behavioral Consultant III shall meet all of the following staffing requirements:**
- *Licensed* psychologist
- Board certified Behavior Analysis or two years supervised experience with I/DD and extreme challenging behaviors (functional behavioral assessments, development and monitoring behavior plans).

The implementation of the **Behavioral Consultant (II and III)** service definition is effective immediately. The endorsement check sheets and instructions are posted at: http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm.

2. Revision to the **Crisis Respite** definition to provide additional clarifying information.
   - The service takes place in a **licensed respite facility**; Crisis Respite is conducted in a respite facility which is licensed under NC GS 122-C 10 NCAC 27G.5100. The provider is required to obtain **a licensure rule waiver which expands the scope of the licensed service prior to delivery of the service.**
   - Staff Qualifications
     - Complete a training course in North Carolina Interventions (NCI) (parts A & B) or similar behavioral intervention training (approved by DMH/DD/SAS) that addresses a broad range of interventions, from positive reinforcement to physical intervention techniques and successfully complete a learning assessment at the conclusion of the course; and
   - Be supervised by a qualified professional at the bachelor level in 10A NCAC 27G .0100-.0200. Supervision shall be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline. The supervisor shall have completed a training course in NCI (parts A & B) or similar behavioral intervention training (approved by DMH/DD/SAS) that addresses a broad range of interventions, from positive reinforcement to physical intervention techniques, and have successfully completed a learning assessment at the conclusion of the course.
     - A staff member who serves as a Crisis Respite Director shall:
       - Be a qualified professional at the bachelor level in 10A NCAC 27G .0100-.0200;
       - Have completed a training course in NCI (parts A & B) or similar behavioral intervention training (approved by DMH/DD/SAS) that address a broad range of interventions from positive reinforcement to physical intervention techniques and have successfully completed a learning assessment at the conclusion of the course; and
       - Have two years experience in the field of developmental disabilities.

The implementation of the revised Crisis Respite service definition is effective immediately. The endorsement check sheets and instructions are posted at: http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm.

3. Revision to the **Home Support** service definition to provide additional clarifying information regarding provision of service by family members.

- Participants receiving Home Supports may not receive Personal Care Services, or Home and Community Supports on the same day that Home Supports is provided. A participant **may** receive Home Supports one day and other services (Home and Community Supports and/or Personal Care) from another provider on alternate days as indicated in the approved Person Centered Plan.

4. **Added the limitation to disallow individuals who live with minor children from providing services**.
   - Parents, step parents, or adoptive parents **may not** provide services to their minor children. Any other individual residing with a minor child may not provide services to that child**.**

5. Revision to the **Individual Caregiver Training and Education** service definition to provide additional clarifying information.
   - This service may not be provided to participants at the same time of day as: Adult Day Health, Day Supports, Home and Community Supports, Personal Care, Supported Employment, or Specialized Consultative Therapy, Crisis Services, Crisis Respite, Respite, Long Term Vocational Supports. The service MAY be provided to participants at the same time of day they are receiving Home Supports or Residential Supports.

6. Revision to the **Respite** service definition to provide criteria for the use of **Nursing Respite**.
   - The use of Nursing Respite is for those participants, due to either chronic or acute, health diagnoses, require the Skilled Nursing level of care for the brief periods of time the family or primary caregivers are away from the home. For RN Respite, the participant must require monitoring of his/her status that requires response to his/her medical support needs on an on-going basis. The requirements for RN staffing are identified in 21 NCAC 36.0221(c) and 21 NCAC 36.0224.
   - Specific rules for LPN staffing can be found at 21 NCAC 36.0225.
   - Nursing Respite at the RN level may be indicated when the participant has the following needs indicating the individual requires substantial and complex medical care needs:
     1. The individual is receiving intravenous nutrition or drug therapy.
     2. The individual is dependent upon a ventilator.
     3. The individual is dependent on other device-based respiratory support, including tracheotomy care, and tracheal suctioning.
   - Nursing Respite at either the RN or LPN level can only be provided in the participant's home.

7. Revisions to the **Home Modifications** service definition and **Augmentative Communication Device** service definition to add exhaustive language and clarify limitations. Refer to the service definitions for details.

8. Revisions to **Specialized Equipment and Supplies** to add exhaustive language and add financial limitations per year.
   - Specialized Equipment and Supplies may not be purchased through the waiver specifically for use in the school setting.
   - Specialized Equipment and Supplies will be a covered waiver expense **ONLY** when not coverable under the Medicaid Durable Equipment Guidelines and are not available for a child under the age of 21 as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) item.
   - Adaptive car seats for children shall be evaluated using criteria established previously by Children's Special Health Services (CSHS).
   - Written prior authorization must be obtained prior to ordering or delivery of the item/service.
   - This service requires identification of goal directed progress in relationship to the item. Items/services listed within this category **are an exhaustive list.**
   - **Items NOT covered include**: Furniture, appliances, bedding, storage cabinets, whirlpool tubs, and other non-custom items that may routinely be found in a home. Educational supplies and equipment expected to be provided by the school **are not covered**. Items of a recreational nature available for all children regardless of diagnosis **are not covered.**
   - The total maximum allowable amount is $3,000 per waiver year per person. This does not apply to supplies with B-codes.

9. Revision to case management monitoring requirements. The current requirement for monthly face to face monitoring with the participant has changed to quarterly face to face (or more frequently based on the needs of the participant) monitoring. The implementation of this change is effective immediately.

Clinical Policy

The CAP-MR/DD Clinical Policy contains the service definitions, the utilization review guidelines and other clinical elements of the CAP-MR/DD Comprehensive Waiver and Supports Waiver. The service definitions have been modified to be consistent with those changes noted in the Technical Amendment Number One (noted above). The Utilization Review Guidelines are included in Sections 5.1.1, 5.1.2, 5.1.3 and 5.6. Appendix Q includes the *Comparison of Waiver Clinical Policy Section 5* and the *2008 CAP-MR/DD Comprehensive Manual Appendix* P. The Clinical Policy, the Comprehensive Waiver Manual and the Supports Waiver Manual are located at: http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm.

Implementation Plan for the CAP-MR/DD Clinical Policy, CAP MR/DD Comprehensive Waiver and Supports Waiver Manuals and Technical Amendment Number One

The new policies contained in this Implementation Update (inclusive of the Clinical Policy) will be effective February 1, 2011 unless otherwise noted. Participants, guardians and legally responsible persons will have this time to determine alternate support options to ensure the health and safety needs are adequately addressed. Case managers shall work with participants/legally responsible persons to assess the participant's needs and make any needed changes to the participant's person centered plan to meet the new requirements while ensuring services and supports are adequate to meet the health and safety needs of the participant.

In the event a participant can not make the transition to the policy changes by the February 1, 2011 effective date, the DMH/DD/SAS will review the participant's person centered plan and determine if further time is required or if other actions are necessary for the participant to safely make the transition. Other actions may include the case manager securing alternate generic/natural services and supports, etc. The DMH/DD/SAS will work with the LMEs and case managers to ensure the participant's health and safety needs are met.

Participants have due process rights as follows: Persons whose requests for waiver services are denied, reduced, terminated or suspended; denied the provider of their choice; or, denied level of care (LOC) are issued a written notice that states the adverse action, citation supporting the action, and due process of appeal rights for a fair hearing or formal appeal conducted by the Office of Administrative Hearings (OAH). If a consumer is not receiving services, OAH will expedite the hearing request. This notice must be mailed at least 30 days prior to the effective date of the adverse action. If the recipient chooses to appeal the decision, he/she has 30 days from the date the notice is mailed to appeal the decision. Should the recipient appeal within the mandated timeframe and should the recipient currently receive services, those services continue for the pendency of the appeal. N.C.G.S. 150B-31.2(c) allows each recipient to be offered mediation prior to a fair hearing. This mediation takes place outside of OAH. If the mediation successfully resolves the case to the recipient's satisfaction, the case is dismissed. Should the recipient reject the offer of mediation or the mediation is unsuccessful, the case proceeds to fair hearing.

Implementation Schedule for the CAP-MR/DD Clinical Policy, CAP MR/DD Comprehensive Waiver and Supports Waiver Manuals and Technical Amendment Number One

Service Definition	**Effective Date**
Behavioral Consultant	07-01-10
Home Support	All plan/PCPs submitted to the UR vendor on or after, 01/01/11 with a start date of 02/01/11 or after, are required to be in compliance with CAP-MR/DD Clinical Policy regarding Home Supports.
Crisis Respite	07-01-10
Case management monitoring requirements (quarterly face to face)	07-01-10
Utilization Review Guidelines	All plan/PCPs submitted to the UR vendor on or after, 01/01/11 with a start date of 02/01/11 or after, are required to be in compliance with CAP-MR/DD Clinical Policy.

Implementation Schedule for all of the following supports; For items authorized prior to 07-31-10 no change is required. All plans/PCPs/revisions received by UR vendor on or after, 08/01/10 **must** be in compliance with CAP-MR/DD Clinical Policy.	
Augmentative Communication Devices	$10,000 per waiver year
Individual Goods and Services	$1,000 per waiver year
Specialized Consultative Services	$1,500 per waiver year
Specialized Equipment and Supplies	$3,000 per waiver year
Transportation	$2,000 per waiver year
Home Modifications	$15,000 over the life of the waiver, November 1, 2008 through October 31, 2011.
Vehicle Adaptations	$15,000 over the life of the waiver, same as above

Direct Billing for Intellectual and Developmental Disabilities Targeted Case Management Providers

System changes for direct billing of DD targeted case management (TCM) are in process but not yet completed and tested. To ensure cash flow for DD TCM providers, providers must continue billing though the LMEs until August 1, 2010.

DMA is close to receiving the Centers for Medicaid and Medicare Services (CMS) approval for a case rate for DD TCM. It is imperative that DD TCM providers complete and submit their Medicaid enrollment applications immediately in order to access this rate when it is approved.

Update on New Prior Authorization Guidelines for Outpatient Behavioral Health Service Providers, Provisionally Licensed Providers Billing "Incident to" a Physician or through the LME, and CABHAs

Directly Enrolled Licensed Professionals

As stated in the June Medicaid Bulletin and Implementation Update #73, effective July 1, 2010, prior authorizations for all outpatient services, with dates of services July 1, 2010 and forward, will be created for the "Attending Provider Name/Medicaid #" on the ORF2 form. Providers must enter the Attending Medicaid Provider Number (MPN) associated with the Attending National Provider Identifier (NPI) with which they will submit their claims (do not submit NPI on the ORF2). Prior authorization requests will no longer be made for group providers. This applies to all directly enrolled licensed professionals.

Current authorizations for outpatient services will remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010 and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Please see special directions below for professionals providing services under a CAHBA.

Provisionally Licensed Professionals Billing through an LME

Provisionally licensed professionals that bill through the LME will continue to request prior authorization with the LME Medicaid Provider Number (MPN) as the "Attending Provider" and should continue to bill through the LME.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Current authorizations for outpatient services will remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010 and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Provisionally Licensed Professionals Billing "Incident to" a Physician
Provisionally licensed professionals that bill "incident to" a physician should request prior authorization with the Medicaid Provider Number (MPN) of the individual physician as the "Attending Provider." This individual physician MPN is the individual physician that the provisionally licensed professional practices "incident to."

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Current authorizations for outpatient services will remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010 and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Please see all "incident to" guidelines in the March 2009 Medicaid Bulletin.

Outpatient Services Provided in a Critical Access Health Agency (CABHA)

Directly Enrolled Providers under a CABHA
For outpatient services, directly enrolled providers operating under a CABHA are required to submit a new request for prior approval to ValueOptions service for any recipient that will be now seen under a CABHA. Again, these new authorizations will only be required for "CABHA" clients.

In these situations, providers must submit a new request on the ORF2 with their individual "Attending Provider Name/Medicaid #" on the ORF2 form. A new prior authorization will be created for the "Attending Provider Name/Medicaid #."

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Authorizations will not be made to the CABHA MPN.

If a directly enrolled professional already has an authorization for a consumer created for their individual attending MPN, they do not need to request a new authorization if they will be providing services to this consumer under a CABHA. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Provisionally Licensed Providers under a CABHA
Provisionally licensed providers **providing services under a CABHA must bill 'incident to' a physician in the CABHA**. Provisionally licensed staff employed by a CABHA will not bill through the LME; their services will be billed as 'incident to' a physician in the CABHA. For outpatient services, provisionally licensed professionals operating under a CABHA are required to submit a new request for prior approval to ValueOptions for any recipient that will be now seen under a CABHA. Again, these new authorizations will only be required for "CABHA" consumers.

Provisionally licensed professionals that bill "incident to" a physician in a CABHA should request prior authorization with the Medicaid Provider Number (MPN) of the individual physician as the "Attending Provider." This individual physician MPN is an individual physician in the CABHA practice that the provisionally licensed professional practices "incident to."

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Authorizations will <u>not</u> be made to the CABHA MPN.

If a provisionally licensed professional already has an authorization for a consumer created for the CABHA physician's MPN, they do not need to request a new authorization if they will provide services to this consumer under a CABHA. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

Please see all "incident to" guidelines in the March 2009 Medicaid Bulletin.

While DMA understands that getting new prior approval for services already authorized may cause some additional hardship, after carefully considering all options, this process was determined to impose the least burden on all parties.

<u>CABHA Transition Updates</u>

CABHA Medicaid Provider Numbers (MPN)

Several CABHAs have completed the Medicaid enrollment process and may begin billing with the NPI associated with the CABHA on July 1, 2010. CABHAs can continue to bill with current NPI numbers for outpatient and enhanced services until they receive their MPN. Outpatient and Enhanced MPNs will not be end-dated at this time.

Authorization Requests for Enhanced Services under a CABHA

Providers do not need to request a new authorization for an enhanced service that will now be delivered under a CABHA. All current authorizations for enhanced services will remain valid.

When it is time for a new authorization for an enhanced service, CABHAs should submit requests for all enhanced services with the current Medicaid Provider Number (MPN) of the enhanced service. The MPN for an enhanced service is identified by the alpha suffix appended to the core MPN (for example "8300005B"). All authorizations will be made to that current MPN. This is the MPN that providers currently list on the ITR as the "Facility ID." In other words, providers should continue to request authorizations in the same way as they do today.

Authorizations <u>will not</u> be made to the CABHA MPN. Providers should not request authorization with the CABHA MPN. Requests submitted only with the CABHA MPN and not the MPN of the enhanced service will be returned Unable to Process.

CABHA Billing Seminars

As CABHAs are enrolled, HP Enterprise Services will be contacting providers to schedule conference calls to discuss billing guidelines. As more agencies enroll, seminars will be conducted to assist the CABHA community. Seminars will be held at LMEs in the Eastern, Central, and Western portions of the state. Site locations and dates will be announced in future Implementation Updates. In addition, on site visits will be provided by HP upon request. Medicaid claims questions may be directed to HP Enterprise Services, 1-800-688-6696.

CABHA Claims Submission
As a reminder, claims for all CABHA enhanced and outpatient services will be billed using the professional claim (CMS-1500/837P) format. This is the same claim type that is used today for billing enhanced and outpatient services. The CABHA NPI should be listed as the 'billing provider." The "attending provider number" should be the NPI associated with the directly enrolled "attending" provider/physician or the enhanced service for which prior authorization was obtained.

Medicaid claims questions may be directed to HP Enterprise Services, 1-800-688-6696.

CABHA Certification Process Revision
As of the date of this Implementation Update, the order of the activities which make up the process for completing CABHA certification is changed. The processes will be completed in this order:

1. Desk Review
2. Interview
3. Verification Review

Once a provider receives notification of having successfully met the requirements of the Desk Review, they will be contacted to arrange the interview portion of the process. If the elements of the interview are met, the provider will receive notification and they will be contacted to arrange the site visit for a verification review. Following the verification review, the provider will receive a final notification of whether or not they will be certified as a CABHA. If a provider fails to meet the elements of any of the phases of the review process, resubmission of the attestation letter and supporting documentation is required to reinitiate the CABHA certification process. Please refer to Implementation Update #75 for information on resubmissions and how and when that may occur.

Medicaid Enrollment for CABHA Applicants
CABHA applicant agencies that are endorsed for the services that make up their continuum but have not had a response to their application(s) for enrollment for one or both of their continuum services, or for core services, must contact CVS EVC Call Center at 866-844-1113 or email NCMedicaid@csc.com. Priority will be given to issue provider enrollment numbers so that the agency can continue through the CABHA certification process.

Incident Response and Improvement System (IRIS)
As originally communicated in Implementation Update #72, effective July 1, 2010, all MH/DD/SAS providers who are required to participate in the DHHS incident reporting system are required to use NC-IRIS for Level II and III incident submission. The link to IRIS is https://iris.dhhs.state.nc.us/Default.aspx. Providers should contact their LME if they have questions about using this new system.

The *IRIS Technical Manual* is located on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/statspublications/index.htm. Click on *Manuals***,** scroll down to *Incident Response System* then click on *IRIS Technical Manual.*

Also as a reminder, effective July 1, 2010 the ***DHHS Incident and Death Report*** form QM02, will be discontinued.

Community Support Team Providers
As you were informed in Implementation Updates #63 and #65 and Medicaid Bulletins November and December 2009, DMA is engaged in the re-verification of Notifications of Endorsement Actions (NEA) letters for Community Intervention Services and specifically for providers of Community Support Team (CST). CST providers were required to submit the verification packet with appropriate credentials including all current NEAs to qualify for continued enrollment as a provider of CST services. Further verification has also occurred through the endorsing LMEs.

This process is now complete and new provider enrollment numbers have been issued for CST using your core number with a **V suffix** to provide a unique provider number for CST (H2015 HT) separate from other

Community Support services (H0036 HA, HB and HQ) beginning July 1, 2010. With this separation, all new service authorization requests submitted to ValueOptions on July 1st and thereafter must include the V suffix**.**

PLEASE NOTE: If you have already submitted authorization requests for CST on or after July 1 using your number with the B Suffix, please know that ValueOptions has been instructed to transfer automatically any approved requests received from July 1 through July 31 to your number with the V suffix. This will offer a limited 30 day time period to ensure providers are informed of these changes. After July 31, 2010, service requests for CST services will be returned as Unable to Process if the provider number retains the B suffix rather than the V suffix. **Service authorizations approved prior to July 1, 2010, under the B suffix will be honored until these authorizations expire.**

Please be attentive to which suffix you use for billing of claims to HP Enterprise Services. Please note: You must use the NPI associated with the Medicaid provider number that matches the CST authorization for proper adjudication of claims.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
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